PREPARING FOR SCREENING FOR HYPERTENSION IN THE COMMUNITY*

HUGH J. CARROLL, M.D.

Associate Professor of Medicine
State University of New York Downstate Medical Center
Brooklyn, N.Y.

SCREENING for a disease has a most attractive goal—to find the patient in the early stages of a chronic process and to interrupt its dismal natural course. However, the physician must approach a screening program with a certain measure of caution; unless a definable set of conditions is met he may be wasting his time. The World Health Organization recently framed a set of prerequisites for a screening program that might be summarized thus:[1]

1) The therapy for the condition must favorably alter its natural history, not simply by advancing the point in time at which diagnosis occurs, but by improving survival, function, or both. There is no point in screening for a disease that has no effective treatment, unless genetic counseling is a legitimate goal.

2) The disease must be an important health problem in terms of disability of patients.

3) Available health services must be sufficient both to insure diagnostic confirmation among those whose screening is positive and to provide long-term care.

4) Compliance with treatment among asymptomatic patients in whom an early diagnosis has been achieved must be at a level demonstrated to be effective in altering the natural history of the disease in question. If asymptomatic patients will not follow the treatment program, screening is pointless.

The fact that hypertension seems to fulfill these criteria makes screening for hypertension a very appealing undertaking, but even here one must approach a screening program with moderation. Statistics from community-based screening programs frequently show that a great many of those who present themselves are known hypertensives. In addition, although

*Presented in a panel, Case Finding, as part of a *Conference on Developing and Managing Community Programs for the Control of Hypertension* held by the New York Metropolitan Regional Medical Program at the New York Academy of Medicine April 15, 1975.

physicians nowadays generally are more inclined to treat hypertension, the rate of defection of patients from programs of treatment is very high.[2] Sackett[3] points out that five years after the beginning of a randomized clinical trial of screening in London there was no difference in blood pressures between those who had and those who had not undergone periodic testing for hypertension.

Many questions present themselves. Is a program of screening warranted that is not tied directly to a program of treatment and a demonstrably effective program of education for both physicians and patients? Can new techniques for education be devised since the old ones are not very effective? When preparing to undertake a screening program, where should patients be sought? Who should do the actual field work? Where are patients who were lost to the program between initial identification and the start of therapy? What steps can be taken to insure maximum compliance on the part of patients and how can dropouts be brought back into the fold? These are difficult questions to answer and not all the answers are forthcoming. However, the participants in this conference shall summarize where we now stand.

REFERENCES

1. World Health Organization: *W.H.O. Technical Report,* 1971, p. A 24.
2. Wilber, J. A. and Barrow, J. G.: Hypertension—A community problem. *Amer. J. Med. 52:*653, 1972.
3. Sackett, D. L.: Screening for disease: Cardiovascular diseases. *Lancet 2:*1189, 1974.